BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **TIMOTHY J. GELETY, M.D.** Holder of License No. **21851** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0866A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on November 3, 2006. Timothy J. Gelety, M.D., ("Respondent") appeared with legal counsel Heather Hendrix before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 21851 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0866A after being notified a hospital suspended Respondent's privileges. A Board Medical Consultant subsequently reviewed medical records involving certain of Respondent's patients. On March 5, 2005 Respondent performed a laparoscopic procedure on a thirty-seven year-old female patient ("AD") for endometriosis and adhesions. AD had three previous exploratory laparoscopies for similar complaints. On March 6, 2005 AD presented to the emergency department for abdominal and shoulder pain, fever, nausea and urinary tract symptoms. AD's temperature was 99.2 and her bowel sounds were active. AD was admitted and given IV antibiotics. On March 7, 2005 she was evaluated by a physician when

her symptoms continued and her fever did not abate. AD had been transferred to the ICU for tachycardia and the physician reported AD's bowel sounds were absent.

4. On March 9, 2005 AD was evaluated by a surgeon who took her to the operating room suspecting probable bowel perforation. When the physician identified a bowel perforation he performed a diverting enterostomy. AD was discharged on March 23, 2005. The first note written by Respondent is dated March 7, 2005. One note is timed at 1900, the time of another is difficult to interpret and appears to be 1250. Respondent's review of the CT scan report of March 8, 2005 indicated his concern for abscess formation, yet he took no action. Action was only taken on March 9, 2005 when Respondent consulted the surgeon who took AD to surgery. The first note nursing staff has of Respondent seeing AD is over twenty-four hours after she was admitted to the hospital. If an immediate post-surgical patient presents to the emergency room with abdominal pain and Respondent admits the patient by phone for observation pursuant to a diagnosis made by the emergency room physician Respondent does not see the patient until the next morning, unless the patient is acute.

5. The radiologist's impression of the CT scan was "may be post-surgical, but cannot exclude the bowel perforation." Bowel perforation is the most serious complication, other than immediate vascular complication, in a patient that has had three previous laparoscopic surgeries. When he saw AD Respondent wrote in his notes "cannot rule out bowel perforation," yet it was not until three days later when AD continued to be significantly tachycardic and had a urine output in this three-day time frame of 100 or 200 ccs over an eight-hour period of time, that a general surgeon saw AD and took her to operating room within one hour. Respondent testified he admitted AD with a differential diagnosis of post-operative infection or bowel perforation and a CT scan was performed immediately. Respondent reviewed the CT scan with the radiologist and put AD on triple antibiotics and watched her for twenty-four hours. Respondent testified AD was

improved on Monday morning, went bad overnight, and he called for the surgical consult when he saw AD the next morning.

6. The standard of care required Respondent to immediately evaluate and expeditiously treat a patient who presented to the emergency department after laparoscopy with abdominal pain and fever.

7. Respondent deviated from the standard of care because he did not see AD until twenty-four hours after her admission and delayed surgical evaluation until the third admission day despite a CT scan indicating probable abscess formation.

8. AD required a second surgery to repair the injury and underwent an extended hospitalization. The delay in proceeding to surgery could have caused overwhelming sepsis and possible death.

9. On May 27, 2004 Respondent performed laparoscopic surgery on a twenty-eight year-old female patient ("YS"). Post-operatively, YS complained of leg numbness. Anesthesia evaluated YS and tried between 1500 and 2100, without success, to contact Respondent. Anesthesia admitted YS for observation. YS's symptoms resolved and she was discharged on May 28, 2004.

10. Respondent was not concerned about YS's symptoms because it is common for there to be some numbness after surgery when the legs have been in stirrups. Respondent noted even if YS had a nerve injury it was not an acute thing and there was nothing he could do about it – she would have to see a neurologist. Respondent did not examine YS when he received the report of numbness. Respondent was not on-call and at 5:00 when he left the clinic he shut off his cell phone. Respondent did not know if it was clear to staff when he left the hospital that if YS had further difficulties which physician they were to call. Respondent testified there was no acute need for YS to be seen by a neurologist or a surgeon because there was no surgical complication – her vital signs were stable and she was doing fine.

11. When Respondent is not on-call the hospital calls his "on-call" phone number and his nurse practitioner will answer. Respondent was unclear as to whether the "on-call" phone his nurse practitioner answers has the same phone number as his phone or whether there are two on-call numbers. Respondent could only say he knew if the hospital could not contact him, it would contact the nurse practitioner.

12. The standard of care required Respondent to be immediately available to evaluate and treat post-operative complications unless he made other coverage arrangements.

13. Respondent deviated from the standard of care because he was not immediately available following YS's surgery to evaluate and treat her post-operative complication and because he did not make coverage arrangements.

14. Although YS's post-operative complication was mild, there was a potential for more severe problems to present and significant complications could have ensued.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to 32-1401(27)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public") and 32-1401(27) (ll)("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for not evaluating a patient who developed post-operative complications and for not being available in a timely fashion to evaluate another post-operative patient.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 7th day of December, 2006.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of December, 2006 with:
Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
8th day of December, 2006, to:

Heather M. Hendrix
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Timothy J. Gelety, M.D.
Address of Record